STATE HEALTH BENEFIT PLAN

Updater

Georgia Department of Community Health | Division of Public Employee Health Benefits | July 1, 2004

State Health Benefit Plan (SHBP) Members: This **Updater** *is official notification of Plan changes and supersedes any previously published information that conflicts with this* **Updater**. *Please keep this* **Updater** *with your Plan documents for future reference. It will be used with the SHBP* **Summary Plan Description** *(SPD) dated April 1, 2003* to administer the Plan until new SPDs are published. If you are disabled and need this information in an alternative format, call the TDD Relay Service at 800-255-0056 (text telephone) or 800-255-0135 (voice), or write the SHBP at P.O. Box 38342, Atlanta, GA 30334.*

The SPD, all **Updaters** *and certain forms are on the DCH Web site, www.dch.state.ga.us.*

This is the 2nd* **Updater *published since the SHBP SPD dated April 1, 2003.*

Plan changes indicated in this *Updater* are effective July 1, 2004

This ***Updater*** describes significant changes to the State Health Benefit Plan (SHBP) and includes important notices about specific benefits. Numbered sections divide the affected Plan options. The SHBP encourages every member to read the entire ***Updater***, whether the specific changes apply to your current Plan or not.

1 FOR ALL PLAN MEMBERS

- **Subscribers' Social Security Numbers** will be removed from the SHBP ID cards and replaced with a unique policy number randomly assigned to comply with state law by July 1. However, the SHBP will still need the subscriber's Social Security Number included in correspondence and on all forms.

- When the SHBP is secondary, the 365-day deadline for filing nears, and the primary payer has not yet paid, the claim should be filed with the SHBP even without the primary payer's explanation of benefits (EOB). That way the claim still meets the "timely filing" requirements, although it will be denied initially because it was sent in without the primary payer's EOB. The primary payer's EOB still needs to be filed within a year of this denial for the claim to be eligible for benefits. Claims received after these deadlines will be denied.

2 FOR PPO AND INDEMNITY OPTION MEMBERS

- **Effective July 1, 2004,** the current PPO, PPO Choice and Indemnity Options will no longer be available. ***The new PPO, PPO Choice and Indemnity Options are:***
  - > PPO Basic
  - > PPO Premier
  - > PPO Choice Basic
  - > PPO Choice Premier
  - > Indemnity Basic
  - > Indemnity Premier

The medical benefits in these new Plan options are the same as offered under the PPO, PPO Choice and Indemnity Plans for the 2003–2004 Plan year. However, there are significant changes to the pharmacy benefits.

- **Claim Information (SPD, page 68):** The time period for submitting medical, behavioral and prescription drug claims is now within 180 days of the date of service if the SHBP is primary; within 365 days of the date of service if the SHBP is secondary.

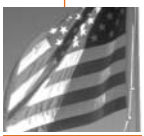
3 PHARMACY BENEFITS

- **Progressive Drug Management Program:** The Progressive Drug Management Program (PDMP) assists your doctor in finding the most appropriate drug treatment(s) for you and your family. The first step is usually to prescribe a proven, less expensive treatment known to be safe and effective for most people. If that drug does not work for you, your doctor may progress to another drug. A Prior Approval may be required. The PDMP helps ensure that you are receiving the most appropriate and cost-effective drug for your condition. The PDMP includes the following therapeutic categories: ACE Inhibitors, Brand NSAIDs, Elidel/Protopic and Glucophage XR.
  Note: This list is subject to change during the Plan year.

PHARMACY BENEFITS EFFECTIVE JULY 1, 2004

Plan Type	Preferred Drug List (PDL)	Generic Co-Payment	Preferred Brand Co-Payment	Non-Preferred Brand Co-Payment	Quarterly Maximum Out-of-Pocket (MOP)
PPO Basic – PPO Choice Basic	Basic	$10	$25	$40	Does not apply
Indemnity Basic	Basic	$10	$25	$40	Does not apply
PPO Premier – PPO Choice Premier	Premier	$15	$25	*20% of cost; minimum $40/ maximum $100	$450 per member/ $1,300 family
Indemnity Premier	Premier	$15	$25	*20% of cost; minimum $40/ maximum $100	$450 per member/ $1,300 family
HMOs – BlueChoice CIGNA UnitedHealthcare	HMO Drug Lists	$10	$25	$40	Does not apply
Kaiser Permanente	Kaiser Drug List	Kaiser Facility $10 / Eckerd Drugs $16	Kaiser Facility $25 / Eckerd Drugs $31	Does not apply	Does not apply

*The co-payments for non-preferred brand drugs do not apply to the quarterly maximum out-of-pocket spending limit.



4 FOR HMO OPTION MEMBERS

- **Kaiser Permanente – Home Healthcare Services:** 100% benefit with Prior Approval; 120 visits maximum per Plan year (formerly 120 days).

- **UnitedHealthcare added counties to their service area.** A complete listing of counties participating in UnitedHealthcare can be found in the July 1, 2004 – June 30, 2005 Health Plan Decision Guide.

5 SPD CLARIFICATIONS/REMINDERS

PPO/Indemnity Members

- **Ambulance Benefits (SPD, page 44):** Emergency, life-threatening, medically necessary ambulance transportation is available to the CLOSEST facility able to treat the condition, even if you are out of the country. If you are traveling outside the U.S. and wish to be transported back into the U.S. for treatment, you may want to consider purchasing travel insurance. If the destination is not the closest facility able to treat the condition, the SHBP will not assume financial responsibility for the additional transportation charges.

Access/Balance Billing Issues

- **PPO Basic and Premier (SPD, page 32):** If there is not an in-network provider in the Georgia service area that can treat your medical condition, you **must** call the MCP for authorization. If the MCP authorizes the out-of-network provider, **in advance**, benefits will be paid at the in-network benefit level. However, because we have no contractual arrangement with the out-of-network provider, you may be balance billed.

- If you receive services in a Georgia service area, you will receive the highest level of benefits if you use an in-network provider. If you need to travel to get treatment you still must use one of the in-network providers (1st Medical Network) to receive the in-network benefits. Access issues do not apply when there is an in-network provider within the Georgia service area who can treat your medical condition. If you reside outside of the Georgia service area – access issues do not apply.

- To locate a network provider, you can call BCBSGA customer service at 1-800-483-6983 or go to the DCH Web site at www.dch.state.ga.us.

- **Indemnity Basic and Premier (SPD, page 34):** There are no access issues for the Indemnity Basic and Indemnity Premier Options because the Plan allows you to seek care from any covered providers; however, there is a difference between in-state and out-of-state benefits. The SHBP holds no contracts outside of Georgia for the Indemnity Basic or Indemnity Premier Options; therefore, the SHBP cannot protect Members from balance billing for services received outside of Georgia or for services received from a non-participating Georgia provider. Members are subject to balance billing. Balance billing may cost you thousands of dollars. **The State Health Benefit Plan does not have the legal authority to intervene when non-participating providers balance bill you. Therefore, the SHBP cannot reduce or eliminate amounts balance billed.**

- **Magellan Access Issues (SPD, page 56):** If a facility is within 60 miles or an individual provider is within 30 miles of a Member's home, there is not an access issue. Magellan will no longer add a provider on an exception basis based on the Member's desire to see an Out-of-Network (OON) provider. If Members wish to select their own provider in the state of Georgia, they should choose one of the **Consumer Choice Options**. Adding a provider on an exception basis can be requested only in cases of access issues. Members should call Magellan for Prior Approval of an access issue.

- **Formal Appeals (SPD, page 72):** Members may not file a Formal Appeal for Plan exclusions; however, they may request an Administrative Review. This Administrative level of review assesses the denial to assure that the determination properly reflects the Plan's guidelines.

- **Disease State Management (DSM) Programs (SPD, page 56):** If you are an active participant in one of the Plan's DSM programs for diabetes, congestive heart failure or asthma, your prescription co-payments may be waived for certain medications related to treatment of the diseases for which you are enrolled. The SHBP must be your primary coverage and you must maintain contact by telephone with a R.N. care manager on a quarterly basis. Certain other restrictions apply. Please call the Medical Certification Program (MCP) at 1-800-790-2507 to obtain more information about participation in the DSM Programs. The MCP staff is available from 9 a.m. to 6 p.m. Eastern time, Monday through Friday.

- **When You Need Cosmetic or Reconstructive Surgery (SPD, page 53):** Surgical procedures that are unable to improve or restore physiologic function are considered cosmetic procedures. The fact that a covered Member may suffer psychological consequences or socially avoidant behavior resulting from the injury, sickness or congenital anomaly does not classify surgery done to relieve such consequences or behavior as a covered reconstructive surgery.

- **Excluded Medical/Surgical Services (SPD, page 62) and Services Requiring Prior Approval (SPD, page 36):** Plan Limitation – Skin abrasion/resurfacing procedures (including, but not limited to, chemical peel, dermabrasion and laser treatment) are **not covered** for treatment of acne and chicken-pox scars, scar or tattoo removal or revision, wrinkling of skin, sun spots, stretch marks, telangiectasia and rosacea. For other medical conditions, these procedures **may be** covered if MCP policy/guidelines are met; Prior Approval is required.

- **Sole Source Diabetic Supplies (*Updater*, dated July 1, 2003, page 2):** Diabetic supplies must be purchased at a retail pharmacy to be covered.

- **Prescription Drug Program (SPD, page 53):** Prescription partial co-payments only apply when the pharmacist is unable to fill the whole prescription due to a shortage of the medication.

- **Mid-level providers (SPD, page 51):** Mid-level providers include, but may not be limited to, the following: physician assistants, nurse practitioners, midwives and certified registered nurse anesthetists. There are coverage limitations for mid-level providers.
  - > **For PPO Basic, PPO Premier, PPO Choice Basic and PPO Choice Premier Options:**
    - All of the physician assistants, nurse practitioners, midwives and certified registered nurse anesthetists are covered if they participate in the 1st Medical PPO Network.
    - Only in-network midwives and certified registered nurse anesthetists are covered in the Beech Street PPO network; physician assistants and nurse practitioners are not covered regardless of their participation in the Beech Street PPO.
    - Out-of-network mid-level providers are not covered.

  - > **For the Indemnity Basic and Indemnity Premier Options:**
    - Physician assistants, nurse practitioners, midwives and certified registered nurse anesthetists are covered for surgical care only. Any other services rendered by these mid-level providers are not covered.

- **Experimental and Investigative Care (SPD, page 51):** The last paragraph of this section now should read: However, effective June 1, 2002, the Plan began covering procedures and supplies associated with cancer clinical trials that meet guidelines established by the Georgia Cancer Coalition Agreement and performed in the state of Georgia.

- **The Indemnity Option provider (SPD, page 33):** A directory is available on the Blue Cross Blue Shield Web site at www.bcbsga.com.

- **Hospice Deductible for the Indemnity Option (SPD, page 46):** The hospital deductible does not apply for hospice care.

All Members

- **Dependent Audit (SPD, page 14):** SHBP continues to conduct random audits of Plan Members' eligibility. Official documentation includes copies of certified marriage licenses for spouses and copies of certified birth certificates, court orders or adoption papers for children or stepchildren. Failure to provide the requested documentation within sixty days of the request will result in the termination of the dependent's coverage retroactively to his or her coverage effective date. The recovery process to recover any and all payments made by the Plan on behalf of any ineligible dependents will begin 30 days after notification of cancellation.

DCH Health Privacy Notice

- **HIPAA Privacy Rule (SPD, page 97):** The SHBP may not speak with anyone but you about your health information. The Health Insurance Portability and Accountability Act (HIPAA) prohibits the SHBP and its vendors from speaking or sharing protected health information with anyone except the patient (this applies also to dependents age 18 and over). If a patient wants to give the SHBP permission to discuss his or her protected health information with others, he or she can designate another person as their personal representative. Patients may request the Personal Representative Form from BCBS Member Services at (404) 233-4479 or (800) 483-6983 or print it from the DCH Web site at www.dch.state.ga.us. If the patient is incapacitated, the representative must have medical power of attorney or court-ordered guardianship. If the patient is deceased, his or her health information is still protected under the law. The executor of the estate must send in a letter of testamentary to the SHBP allowing release of the information.